STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
WAGE STANDARDS DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 340, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR COMPLAINT FORM WSD-1.378 III

Chapter 378, Employment Practices, Part III,
Unlawful Suspension or Discharge Due to Work Injury

Instructions

Please completely fill out the WSD-1.378 III Complaint Form.

You must file a complaint within 30 days of either: (1) the date of the alleged violation, (2) the date you learned of the alleged violation, or (3) the date you were released to return to work from a work injury.

Please type or print legibly. Read all instructions before completing the forms. If you have any questions, call the nearest office at the number listed below.

WSD-1 Complaint Form

Page 1 of 3:

Items 1 through 6, and 8, 9: Provide information pertaining to yourself.
Item 7: **Insert the following: "See Statement of Facts on the following page".**
Items 10 through 14: Provide information about the employer you are filing a complaint against.

Page 2 of 3:

Statement of facts:

(a) If you believe the employer violated Section 378-32, Hawaii Revised Statutes (HRS), please provide a short statement, including the alleged unlawful act and the date it occurred. For example:
"I believe the employer violated Section 378-32, HRS, because I was (discharged, suspended, or discriminated against) on (date) due to
- my work injury;
- my pay being garnisheed; or
- my filing for a wage earner plan under Chapter XIII of the Bankruptcy Act."

(b) State the remedy you are seeking. For example, back pay, reinstatement, or both.

Verification and Signature:

Your signed complaint must be verified by an authorized Department of Labor and Industrial Relations representative. **You will be required to produce identification. If you mail your complaint, it must be signed before a notary public.**

Page 3 of 3:

Complete and sign the attachment form.

Under Item 9 of the attachment, briefly describe how the employer committed the alleged violation by providing a short summary of instances or examples which support your allegation. If more space is needed, please attach another sheet.

IMPORTANT: Report any change of address or telephone number. If we are unable to contact you, your complaint will be dismissed.

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The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly. ***If we do not receive the required forms, the processing of your complaint may be delayed. You may include copies of any documents, records, pay statements, etc. to support your complaint.***

Please remember to sign and date the form before submitting it.

For additional information, "A Guide to Administrative Hearings at the DLIR Wage Standards Division" is available at this website: www.hawaii.gov/labor.

Delivery Information

Delivery by U.S. Mail or In-Person

Department of Labor and Industrial Relations, Wage Standards Division

Oahu	Hilo	West Hawaii
Princess Keelikolani Building, 830 Punchbowl Street, Rm. 340, Honolulu, HI 96813 Phone: (808) 586-8777	State Building, Rm. 108, Hilo, HI 96720 Phone: (808) 974-6464	Post Office Building, P.O. Box 49, Kealakekua, HI 96750 Phone: (808) 322-4808
Kauai	**Maui**	
3060 Eiwa Street, Rm. 202, Lihue, HI 96766 Phone: (808) 274-3351	2264 Aupuni Street, Wailuku, HI 96793 Phone: (808) 984-2075	

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

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COMPLAINT FORM WSD-1.378 III

Chapter 378, Employment Practices, Part III, Unlawful Suspension or Discharge Due to Work Injury

Please print or type and follow the "Instruction Sheet for Complaint Form WSD-1.378 III"

Complainant Information

1. Name (Last, First, Middle Initial) ☐Mr. ☐Mrs. ☐Ms.			2. Social Security Number
3. Address	City	State	Zip Code
4. Phone ( )	Cell Phone ( )		
5. Type of Work Performed			
6. Employment Status ☐Current Employee of Employer Named Below ☐Quit ☐Discharged			
7. If No Longer Employed, Reason			
8. Date(s)/Period of Employment	From	To	
9. Union Membership ☐Yes ☐No If yes, Name of Union:			

Employer Information

10. Business Name			
11. Address	City	State	Zip Code
12. Phone ( )	Fax ( )		
13. Name and Title of Owner or Person in Charge			
14. Nature of Business			

FOR OFFICE USE ONLY			Law				
Date Received			ICB				
			CS				
Taken by		DOL#:	IS1		IS2		
	H K M WH		HB			**No.**	

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(Rev. 10/05)

Statement of Facts (Briefly explain pertinent facts of the alleged violation):

I swear or affirm that I have read this complaint, and that the information and statements are true to the best of my knowledge and belief. I authorize the Director of Labor and Industrial Relations or a departmental representative to collect and receive, on my behalf, payments made on my complaint.

Note: Do not date or sign unless in the presence of an authorized DLIR representative or a notary public.

Date: _____ Signature of Complainant: _____

☐ *Check if under 18 years old*

FOR OFFICE USE ONLY: VERIFIED BY: _____ Authorized DLIR Representative _____, 2_____	STATE OF HAWAII) } SS. COUNTY OF _____) Subscribed and sworn to before me this _____ day of _____, 2_____ _____ Notary Public, _____ Judicial Circuit, State of Hawaii My commission expires _____

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1. Alleged unlawful act: ☐ Discharge ☐ Suspension ☐ Discrimination	2. Date of discharge, suspension or discrimination
3. Reason: ☐ Injured on the job ☐ Wages were garnished ☐ Filed bankruptcy	

For work injury termination complaints:

4. a. Date of work injury		b. Type of work injury (e.g., neck, back, arm, leg, stress, etc.)	
5. a. Have you been released by your doctor to return to work? ☐ Yes ☐ No			
b. If yes:	Date released for work:	Released with limitations ☐ Yes ☐ No	
6. a. Have you filed a workers' compensation claim for this injury? ☐ Yes ☐ No		b. Has your claim been approved? ☐ Yes ☐ No ☐ Pending	
7. Did the employer have three or more employees at the time of your work injury? ☐ Yes ☐ No ☐ Unsure			
8. If union member:			
a. Does the collective bargaining agreement prevent continued employment or reemployment of an employee who suffers a work injury? ☐ Yes ☐ No ☐ Unsure			
b. Have you filed a grievance with the union relating to allegations made in this complaint? ☐ Yes ☐ No			
9. Remarks relating to your allegation:			

The above information is true to the best of my knowledge.

Print Name_____

Signature_____

Date_____

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